

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07593 290**

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b <i>9 da.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Grasonville</i> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <i>Jacob B Baker</i>		4. DATE OF DEATH Month <i>7</i> Day <i>26</i> Year <i>1956</i>		5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 1, 1899</i>		9. AGE (In years last birthday) <i>56</i> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>Jacob B Baker, Sr.</i>						14. MOTHER'S MAIDEN NAME <i>Ella Collier</i>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>217-12-4666</i>						17. INFORMANT Address <i>Mrs. Mabel Baker (Wife)</i> <i>Grasonville Md.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>916.5</i> DUE TO <i>Reenact of 2nd & 3rd degree burns over</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>one half of body gas engine explosion</i> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____																					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____															
20c. TIME OF INJURY Month, Day, Year <i>7/17 1956</i> Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Public's Handing</i>				20f. (City or town) <i>Grasonville</i> (County) _____ (State) _____											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>W. Henry Fisher</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
EXAMINER'S NAME (Type) _____						DATE SIGNED <i>7/26/56</i>															
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>July 28-1956</i>		22c. NAME OF CEMETERY OR <i>Grasonville</i>				22d. LOCATION (City, town, or county) <i>Grasonville Maryland</i> (State) _____											
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Fisher</i>						ADDRESS <i>Centerville Md.</i>						24a. REC'D BY REGISTRAR DATE <i>7-28-56</i>		24b. REGISTRAR'S SIGNATURE <i>T. H. Newen</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

Mr. No. 517-15-466

One copy of body & engine application
Received of Mr. J. J. [unclear] [unclear]

Understanding to [unclear]

BUREAU V. 1

AUG 1 1956

RECEIVED

U.S. Census Bureau

Received July 28-1956
[unclear] [unclear] [unclear]
[unclear] [unclear] [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08690	
Item 20 Film G201 8-17-56 ams										Reg. Dist. No. 290	
7613										CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>					c. LENGTH OF STAY IN 1b <i>17 da.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial</i>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>E</i> Last <i>Bartlett</i>					4. DATE OF DEATH Month <i>July</i> Day <i>29</i> Year <i>1956</i>						
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 30, 1870</i>		9. AGE (In years last birthday) <i>86</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Joseph Bartlett</i>					14. MOTHER'S MAIDEN NAME <i>Nancy Seymour</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Pauline Dickerson</i> Address <i>Trappe</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i> <i>904.9</i> DUE TO <i>Fracture left hip.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Open reduction 16 July '56</i>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>July 12 1956</i> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>219 S. Washington ST. 31 July 56</i> DATE SIGNED <i>31 July 56</i> ACTUAL SIGNATURE <i>Old Schmidt</i> M.D. <i>E.C.H. Schmidt</i> <i>Easton, Md</i> PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>											
22a. BURIAL, CREMATIONS, REMOVAL (Specify)					22b. DATE THEREOF <i>July 31, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Easton, Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marion E. Newman + Son</i>					ADDRESS		24a. REC'D BY REGISTRAR <i>8-6-56</i>		24b. REGISTRAR'S SIGNATURE <i>N.H. Neuman</i>		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		RE-MARRIED		RE-MARRIED		RE-MARRIED	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH	
STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH	
STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH	

RECEIVED
AUG 9 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7614

CERTIFICATE OF DEATH

07595

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Butler</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>5</u> IF UNDER 1 YEAR Months Days Hours Mins IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Glenn C. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Phyllis Asmusen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Glenn C. Butler</u>		Address <u>Denton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> 75% DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Breath extraction</u> DUE TO (c) <u>Polycystic disease of Kidneys</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>July 17</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St. 1956</u> DATE SIGNED <u>July 19, 1956</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		M.D. <u>219 S. Washington St. 1956</u> <u>Denton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 18, 1956</u>	<u>Greenmount</u>	<u>Hallaboro, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Brown</u>		ADDRESS <u>Denton, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>7-18-56</u>
		24b. REGISTRAR'S SIGNATURE <u>N.H. Neekies</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. 5

JUL 23 1956

RECEIVED

7615

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>0522</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Carmine</u> Last <u>Carmine</u>		4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1873</u>
9. AGE (In years and birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin M. Harper</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Higgins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>L. C. Haines</u> (Daughter)		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poss. mesenteric thrombosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO <u> </u> (c) <u>ASCVD & arr. fibrillation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>3d</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>2-12-56</u> , 19 <u> </u> , to <u>7-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>56</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Federalsburg, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>R. C. Kingsbury</u> M.D.		PHYSICIAN'S NAME (Type) <u>R. C. KINGSBURY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>17-13-56</u>		22b. DATE THEREOF <u>17-13-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. C. Haines</u>		ADDRESS <u>Preston</u>	
24a. REC'D BY REGISTRAR DATE <u>7-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Neuren</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER					
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER					
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY					
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF OTHER	

RECEIVED
JUL 19 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7616

CERTIFICATE OF DEATH

07597

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels, Md.</u>	
c. LENGTH OF STAY IN 1b <u>33 hrs</u>		d. STREET ADDRESS <u>704 Talbot St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Caulk</u> Last <u>Caulk</u>		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-96</u> AG (In years last birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Fall</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hannigan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph F. Caulk, Jr. - St. Michaels, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma sigmoid - generalized metastatic</u> DUE TO (b) <u>cachexia - generalized</u> DUE TO (c) <u>intestinal obstruction - metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 10, 1952</u> to <u>July 8, 1956</u> , that I last saw the deceased alive on <u>July 8, 1956</u> , and that death occurred at <u>10:42 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thym B. Reeser</u>		ADDRESS (Street, city or town, state) <u>St. Michaels Md</u> DATE SIGNED <u>7-8-56</u>	
PHYSICIAN'S NAME (Type) <u>Thym B. Reeser</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 10, 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elmest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>		ADDRESS <u>St. Michaels Md</u>	
24a. REC'D BY REGISTRAR <u>7/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. D. Reeser</u>	

CERTIFICATE OF DEATH

7018

NAME OF DECEASED <i>John Doe</i>		SEX Male	
AGE 45		DATE OF BIRTH 10-15-1910	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE 12-1-1935	
NAME OF SPOUSE Jane Doe		PLACE OF MARRIAGE Baltimore, Md.	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH 7-10-1956		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	

BUREAU V. 5

JUL 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07598

CERTIFICATE OF DEATH

Reg. Dist. No. 290

7628

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bellhove</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bellhove</u>		TOWN <u>Rural Bellhove</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Clara</u> (Middle) <u>Helen</u> (Last) <u>Clark</u>				(Month) <u>July</u> (Day) <u>12</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10, 1890</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Glenn Krantzman</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Clara Clark Bellhove</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>744.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-30-1953</u> , to <u>7-12-1956</u> , that I last saw the deceased alive on <u>7-12-1956</u> and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Donald H. Bradley M.D.</u>				DATE SIGNED <u>9 N. Hanson St. Easton Md. 7-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>July 14, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>N. H. Neerix</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Ellis Clark</u>		ADDRESS <u>Easton Md</u>	
DATE <u>7-14-56</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MEDICAL EXAMINATION

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF BURIAL

14. SIGNATURE OF CREMATION

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

BUREAU V. S.

JUL 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07599

CERTIFICATE OF DEATH

Reg. Dist. No. 290

7617

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>113 N. Washington St.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Conaway</u>		4. DATE OF DEATH <u>July 23 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-56</u>
9. AGE (In years last birthday) <u>10</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Conaway</u>		14. MOTHER'S MAIDEN NAME <u>Bertie Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Bertie Conaway</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>771.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intracerebral hemorrhage</u> (c) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-23-</u> 19 <u>56</u> , to <u>7-23-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>7-23-</u> 19 <u>56</u> , and that death occurred at <u>2:45</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald A. Baitley</u> M.D.		ADDRESS (Street, city or town, state) <u>977 Hanson St. Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Donald A. Baitley</u>		DATE SIGNED <u>7-23-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>7/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital - Easton Md</u>		24. REC'D BY REGISTRAR <u>A. H. Pearson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. **07600** **290**

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Windy Hill		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Conklin		4. DATE OF DEATH Month July Day 12 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Vernon Conklin Address Windy Hill, Trappe, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X apoplexy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) H.C.V.D DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH Cudden Several yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from 2/9/ , 19 56 , to 7/12/ , 19 56 , that I last saw the deceased alive on 4/26/ , 19 56 , and that death occurred at 6:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED Easton, Md. ACTUAL SIGNATURE P. E. Cox M.D. Easton, Md. PHYSICIAN'S NAME (Type) Dr. P. E. Cox Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 7-15-56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE McGee Funeral Home ADDRESS 1130 E. 3rd St		24a. REC'D BY REGISTRAR 245-576	24b. REGISTRAR'S SIGNATURE N. H. Neenan

CERTIFICATE OF DEATH

1956

Name of Deceased		Date of Death	
John Doe		July 15, 1956	
Age		Sex	
45		Male	
Place of Birth		Cause of Death	
New York City		Heart Disease	
Occupation		Date of Burial	
Teacher		July 18, 1956	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

JUL 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07601

7630

CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WITTMAN		c. LENGTH OF STAY IN 1b 10 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WITTMAN		d. STREET ADDRESS _____	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY E. DULIN		4. DATE OF DEATH JULY 4 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN DULIN		14. MOTHER'S MAIDEN NAME ALICE JACKSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-7648	
17. INFORMANT S. EVERETT DULIN, ST. MICHAELS, MD.		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma prostate, generalized metastatic 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cachexia - Generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-12 , 19 53 , to 7-4 , 19 56 , that I last saw the deceased alive on 7-4 , 19 56 , and that death occurred at 2:00 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Guy M. Reeser Jr.		ADDRESS (Street, city or town, state) St. Michaels Md. DATE SIGNED 7-6-56	
PHYSICIAN'S NAME (Type) Guy M. Reeser Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 6, 1956	
22c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEMETERY		22d. LOCATION (City, town, or county) (State) EASTON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lamberton Harrison		ADDRESS St. Michaels	
24a. REC'D BY REGISTRAR Guy M. Reeser Jr.		24b. REGISTRAR'S SIGNATURE Mrs. Robert R. Selt	

CERTIFICATE OF DEATH

NAME OF DECEASED WITTMAN		DATE OF DEATH 1956	
AGE 2		SEX MALE	
RACE WHITE		EDUCATION GRADUATE	
OCCUPATION DRIVER		MANNER OF DEATH ACCIDENT	
PLACE OF DEATH HOME		CITY BALTIMORE	
COUNTY JOHN DAY		STATE MARYLAND	
DATE OF BIRTH 1954		PLACE OF BIRTH JOHN DAY	
DATE OF DEATH 1956		PLACE OF DEATH HOME	
CITY BALTIMORE		STATE MARYLAND	
COUNTY JOHN DAY		MANNER OF DEATH ACCIDENT	
OCCUPATION DRIVER		EDUCATION GRADUATE	
RACE WHITE		AGE 2	
NAME OF DECEASED WITTMAN		DATE OF DEATH 1956	

BUREAU V. S.

JUL 9 1956

RECEIVED

7618

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>20 hrs 35 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Howard</u> Last <u>GARDNER</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14 1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		IF UNDER 24 HRS. Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John W. GARDNER</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>John W. GARDNER, Son</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) <u>5 yrs -</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1-9-50</u> , 19 <u>50</u> , to <u>7-26-1956</u> , that I last saw the deceased alive on <u>7-26-1956</u> , and that death occurred at <u>1251</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	
22d. LOCATION (City, town, or county) <u>Easton</u>				22e. (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll, Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 1 1956

RECEIVED

7631
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ----		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First MARTIN Middle G. Last GREEN		4. DATE OF DEATH Month July Day 15 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1887
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) Trappe, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-8995	
17. INFORMANT Josephine Green, St. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 mon 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 March, 1936 , to 15 July, 1956 that I last saw the deceased alive on 15 July , 1936, and that death occurred at 11:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Paul Wright M.D.		ADDRESS (Street, city or town, state) St. Michaels, Maryland DATE SIGNED 16 July 56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1956	22c. NAME OF CEMETERY OR CREMATORY Richards Memorial Cemetery, Easton, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. Hamilton Harrison, St. Michaels, Md		24a. REC'D BY REGISTRAR DATE 7/18/56	
24b. REGISTRAR'S SIGNATURE Mrs Robert L. Seck			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JUL 10, 1887		BALTIMORE		MD.		MD.		U.S.A.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
FARMER		HEART DISEASE		NATURAL		2 WEEKS		JUL 15, 1956		BALTIMORE		MD.		U.S.A.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JUL 19 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>R.</u> Middle <u>GRIFFIN</u> Last		4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 21, 1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL GROCER</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN J. GRIFFIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH PENMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-2919</u>	
17. INFORMANT <u>John T. Griffin</u>		Address <u>St. Michaels Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Dis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH. <u>6 min</u> <u>4 years</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1 Aug</u> , 19 <u>56</u> , to <u>29 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 July</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wadsworth</u>		M.D. <u>St. Michaels, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>7-31-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 1, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampeston Harrison</u>		ADDRESS <u>St. Michaels Md</u>	
24a. REC'D BY REGISTRAR <u>7/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Miss Robert L. Seth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

AUG 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07605

7633

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Trappe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Trappe, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Annie Middle Kemp Last Hilditch		4. DATE OF DEATH Month July Day 25 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1856
9. AGE (In years last birthday) 100 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Jefferson Kemp		14. MOTHER'S MAIDEN NAME Claricy Wyatt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Gladys Hilditch		Address Trappe, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1956 to July 25, 1956 that I last saw the deceased alive on July 25, 1956 and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William S. Seymour M.D.		ADDRESS (Street, city or town, state) Trappe, Maryland. DATE SIGNED July 26, 1956	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE M. E. Seymour Son		ADDRESS Easton Md.	
24a. REC'D BY REGISTRAR DATE 7/27/56		24b. REGISTRAR'S SIGNATURE N. H. Neer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15 1911		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Report		Place of Report	
July 20 1956		10:30 AM		Home		Baltimore, Md.		Heart Disease		Natural		Teacher		[Signature]		[Signature]		July 20 1956		Baltimore, Md.	

RECEIVED
JUL 30 1956
BUREAU W. K.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7619

CERTIFICATE OF DEATH

Reg. Dist. No. 290

07606

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>Federalsburg</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Goldie</u> Middle <u>Jenier</u> Last <u>Holmes</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27, 1955</u>	
9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>7</u>		IF UNDER 24 HRS. Days <u>14</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Paul Louvin Holmes</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Edna Holmes Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Roberta Holmes (Mother)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE ENTERO-COLITIS</u> 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>12-18 HRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>DOA</u> , 19 <u>56</u> , to <u>11 40</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 40</u> , 19 <u>56</u> , and that death occurred at <u>11 40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.H. Owens, Jr.</u>				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>A.H. Owens, Jr.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Goldboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulain</u>				ADDRESS <u>Greensboro Md.</u>		24a. REC'D BY REGISTRAR <u>N.H. Neerix</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>7/5/56</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07607

7634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. LENGTH OF STAY IN 1b <u>40 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rio Vista Nursing Home-St. Michaels</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Dashiell Jesse</u>			4. DATE OF DEATH Month Day Year <u>July 16 19 56</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1880</u>		9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Princess Anne, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Rufus W. Dashiell</u>				14. MOTHER'S MAIDEN NAME <u>Laura Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>H. L. Brittingham</u> Address <u>1770 Columbia Rd., NW Washington 9, D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac failure-chronic</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia-generalized</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-10</u> , 19 <u>53</u> to <u>7-16</u> , 19 <u>56</u> that I last saw the deceased alive on <u>7-16</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>7-18-56</u>							
ACTUAL SIGNATURE <u>Guy M. Reeser</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Talbot, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u> ADDRESS <u>St. Michaels, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>July 18, 56</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Robert R. Seeh</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		JAN 15 1870		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
Carpenter		Heart Disease		Natural		Several Months		JUL 15 1956		BALTIMORE		MD		USA	
FATHER'S NAME		MOTHER'S NAME		SPOUSE'S NAME		CHILDREN		EDUCATION		RELIGION		RACE		COLOR	
JAMES H. HARRIS		MARY J. HARRIS		JANE HARRIS		3		High School		Roman Catholic		White		White	
BIRTH RECORD		DEATH RECORD		BURIAL RECORD		VITAL RECORD		MARRIAGE RECORD		DIVORCE RECORD		WEDDING RECORD		FUNERAL RECORD	
JUL 15 1956		JUL 15 1956		JUL 15 1956		JUL 15 1956		JUL 15 1956		JUL 15 1956		JUL 15 1956		JUL 15 1956	

RECEIVED
JUL 23 1956
BUREAU V. S.

7635

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAVITT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAVITT</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First <u>GLADYS</u> Middle <u>M.</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25 1895</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEAVITT, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN W. HARRISON</u>				14. MOTHER'S MAIDEN NAME <u>MARY E BALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-34-7408</u>		17. INFORMANT <u>Edward J. Neavitt</u>		Address <u>Neavitt Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma Brain - glioblastoma</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia - generalized</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-2-1953</u> , to <u>7-14-56</u> , that I last saw the deceased alive on <u>7-14-56</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Guy M. Reeser Jr</u>				ADDRESS (Street, city or town, state) <u>St Michaels Md</u>			
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser Jr</u>				DATE SIGNED <u>7-16-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEAVITT CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAVITT, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Hampton Harrison</u>				ADDRESS <u>St. Michaels Md</u>		24a. REC'D BY REGISTRAR <u>Mr. Robert L. Seck</u>	
				DATE <u>7/16/56</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 18 1956

BUREAU V.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

7620

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton		c. LENGTH OF STAY IN 1b 2 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 80 Memorial Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Percy Middle Jones Last				4. DATE OF DEATH Month 7 Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1955	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME George Jones				14. MOTHER'S MAIDEN NAME Matilda Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Matilda Turner (Mother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apparently due to satting aspirin tablets 872.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) According to Dr. W. Henry Fisher the (c) Certificate is as sent in from Queen Anne County PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. Henry Fisher				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF 7/15/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Stevensville Md (R)	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE M.A. Neeress	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL		20. SIGNATURE OF CREMATION		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
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43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
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58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

SEP 4 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records or for a burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07609

7635

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Michaels outside		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WITTMAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Henry First Lester Middle Palmer Last		4. DATE OF DEATH July Month 7 Day 1956 Year	
5. SEX MALE	6. COLOR OR RACE NRANA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 26
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER		10b. KIND OF BUSINESS OR INDUSTRY HOUSING	11. BIRTHPLACE (State or foreign country) Wittman Md
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME H. Lester Palmer	
14. MOTHER'S MAIDEN NAME Henritta Trott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korea	
16. SOCIAL SECURITY NO. 214-30-8636		17. INFORMANT Lester Palmer, Wittman Md Address	
18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO Auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Auto accident DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit run	
20c. TIME OF INJURY Month, Day, Year 11:20 p.m. 7-7 1956	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) St Michaels TAL Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Louis A. Merty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) LOUIS S. MELTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1956	
22c. NAME OF CEMETERY OR CREMATORY Claiborne Cemetery		22d. LOCATION (City, town, or county) (State) Claiborne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Samuelton Harrison		ADDRESS St. Michaels Md	
24a. REC'D BY REGISTRAR 7/8/56		24b. REGISTRAR'S SIGNATURE Mrs. Robert K. Selt	

STATE DEPARTMENT OF HEALTH - DAY ONE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE

TIME

PLACE

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF EXAMINATION

PLACE OF EXAMINATION

DATE OF INTERVIEW

PLACE OF INTERVIEW

DATE OF POSTMORTEM

PLACE OF POSTMORTEM

DATE OF AUTOPSY

PLACE OF AUTOPSY

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF BURIAL

PLACE OF BURIAL

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

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PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF CREMATION

PLACE OF CREMATION

BUREAU V. E.

JUL 10 1956

RECEIVED

1 7621 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

07610
 Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shenwood</u>	
c. LENGTH OF STAY IN b. <u>10 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Reed</u> Last <u>Reed</u>		4. DATE OF DEATH <u>JULY 15</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1916</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Tobin</u>		14. MOTHER'S MAIDEN NAME <u>Susie Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Brown Reed</u> Address <u>Shenwood, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO <u>arteriosclerotic cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>422.1</u> DUE TO <u>260X</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>56</u> , to <u>7-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-15</u> , 19 <u>56</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James B. Dashiell</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>7-16-56</u>	
PHYSICIAN'S NAME (Type) <u>Harry M. Reeder Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/22/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Int. Calvary Bpt. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Exmore, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>N. B. Neenan</u> DATE <u>7-20-56</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. SIGNATURE OF PHYSICIAN _____</p>	
<p>10. SIGNATURE OF REGISTRAR _____</p>		<p>11. SIGNATURE OF WITNESS _____</p>		<p>12. SIGNATURE OF DECEASED _____</p>	
<p>13. SIGNATURE OF DECEASED _____</p>		<p>14. SIGNATURE OF DECEASED _____</p>		<p>15. SIGNATURE OF DECEASED _____</p>	
<p>16. SIGNATURE OF DECEASED _____</p>		<p>17. SIGNATURE OF DECEASED _____</p>		<p>18. SIGNATURE OF DECEASED _____</p>	
<p>19. SIGNATURE OF DECEASED _____</p>		<p>20. SIGNATURE OF DECEASED _____</p>		<p>21. SIGNATURE OF DECEASED _____</p>	
<p>22. SIGNATURE OF DECEASED _____</p>		<p>23. SIGNATURE OF DECEASED _____</p>		<p>24. SIGNATURE OF DECEASED _____</p>	
<p>25. SIGNATURE OF DECEASED _____</p>		<p>26. SIGNATURE OF DECEASED _____</p>		<p>27. SIGNATURE OF DECEASED _____</p>	
<p>28. SIGNATURE OF DECEASED _____</p>		<p>29. SIGNATURE OF DECEASED _____</p>		<p>30. SIGNATURE OF DECEASED _____</p>	
<p>31. SIGNATURE OF DECEASED _____</p>		<p>32. SIGNATURE OF DECEASED _____</p>		<p>33. SIGNATURE OF DECEASED _____</p>	
<p>34. SIGNATURE OF DECEASED _____</p>		<p>35. SIGNATURE OF DECEASED _____</p>		<p>36. SIGNATURE OF DECEASED _____</p>	
<p>37. SIGNATURE OF DECEASED _____</p>		<p>38. SIGNATURE OF DECEASED _____</p>		<p>39. SIGNATURE OF DECEASED _____</p>	
<p>40. SIGNATURE OF DECEASED _____</p>		<p>41. SIGNATURE OF DECEASED _____</p>		<p>42. SIGNATURE OF DECEASED _____</p>	
<p>43. SIGNATURE OF DECEASED _____</p>		<p>44. SIGNATURE OF DECEASED _____</p>		<p>45. SIGNATURE OF DECEASED _____</p>	
<p>46. SIGNATURE OF DECEASED _____</p>		<p>47. SIGNATURE OF DECEASED _____</p>		<p>48. SIGNATURE OF DECEASED _____</p>	
<p>49. SIGNATURE OF DECEASED _____</p>		<p>50. SIGNATURE OF DECEASED _____</p>		<p>51. SIGNATURE OF DECEASED _____</p>	
<p>52. SIGNATURE OF DECEASED _____</p>		<p>53. SIGNATURE OF DECEASED _____</p>		<p>54. SIGNATURE OF DECEASED _____</p>	
<p>55. SIGNATURE OF DECEASED _____</p>		<p>56. SIGNATURE OF DECEASED _____</p>		<p>57. SIGNATURE OF DECEASED _____</p>	
<p>58. SIGNATURE OF DECEASED _____</p>		<p>59. SIGNATURE OF DECEASED _____</p>		<p>60. SIGNATURE OF DECEASED _____</p>	
<p>61. SIGNATURE OF DECEASED _____</p>		<p>62. SIGNATURE OF DECEASED _____</p>		<p>63. SIGNATURE OF DECEASED _____</p>	
<p>64. SIGNATURE OF DECEASED _____</p>		<p>65. SIGNATURE OF DECEASED _____</p>		<p>66. SIGNATURE OF DECEASED _____</p>	
<p>67. SIGNATURE OF DECEASED _____</p>		<p>68. SIGNATURE OF DECEASED _____</p>		<p>69. SIGNATURE OF DECEASED _____</p>	
<p>70. SIGNATURE OF DECEASED _____</p>		<p>71. SIGNATURE OF DECEASED _____</p>		<p>72. SIGNATURE OF DECEASED _____</p>	
<p>73. SIGNATURE OF DECEASED _____</p>		<p>74. SIGNATURE OF DECEASED _____</p>		<p>75. SIGNATURE OF DECEASED _____</p>	
<p>76. SIGNATURE OF DECEASED _____</p>		<p>77. SIGNATURE OF DECEASED _____</p>		<p>78. SIGNATURE OF DECEASED _____</p>	
<p>79. SIGNATURE OF DECEASED _____</p>		<p>80. SIGNATURE OF DECEASED _____</p>		<p>81. SIGNATURE OF DECEASED _____</p>	
<p>82. SIGNATURE OF DECEASED _____</p>		<p>83. SIGNATURE OF DECEASED _____</p>		<p>84. SIGNATURE OF DECEASED _____</p>	
<p>85. SIGNATURE OF DECEASED _____</p>		<p>86. SIGNATURE OF DECEASED _____</p>		<p>87. SIGNATURE OF DECEASED _____</p>	
<p>88. SIGNATURE OF DECEASED _____</p>		<p>89. SIGNATURE OF DECEASED _____</p>		<p>90. SIGNATURE OF DECEASED _____</p>	
<p>91. SIGNATURE OF DECEASED _____</p>		<p>92. SIGNATURE OF DECEASED _____</p>		<p>93. SIGNATURE OF DECEASED _____</p>	
<p>94. SIGNATURE OF DECEASED _____</p>		<p>95. SIGNATURE OF DECEASED _____</p>		<p>96. SIGNATURE OF DECEASED _____</p>	
<p>97. SIGNATURE OF DECEASED _____</p>		<p>98. SIGNATURE OF DECEASED _____</p>		<p>99. SIGNATURE OF DECEASED _____</p>	
<p>100. SIGNATURE OF DECEASED _____</p>		<p>101. SIGNATURE OF DECEASED _____</p>		<p>102. SIGNATURE OF DECEASED _____</p>	

RECEIVED
 JUL 23 1956
 BUREAU V. 3

7622

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>SOUTH CAROLINA</u> b. COUNTY <u>77x3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB <u>1 day 15 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Present address Hurler Mt</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Rouse</u> Last <u>Rouse</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17 1916</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR: Months <u>40</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTH CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ROBERT LEAY</u>		14. MOTHER'S MAIDEN NAME <u>Enna McCreedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>13-17-1916</u>	
17. INFORMANT <u>Burke T. Rouse</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left cerebral hemorrhage</u> DUE TO <u>hypertensive cardio-vascular disease</u> (b) <u></u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2:45</u> P.M. to <u>3:15</u> P.M., that I last saw the deceased alive on <u>2/14/56</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Washington St. 3rd fl. 56</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>2/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity, Fairfax S.C.</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax S. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith S. Killough</u>		ADDRESS <u>East New Market</u>	
24a. REC'D BY REGISTRAR <u>8/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Nevin</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08705

7623

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>140 Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days 5 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Wittman</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>O</u> Last <u>Sewell</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		F UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>3</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Jack Sewell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth E Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>0</u>		17. INFORMANT <u>Mrs Edith Sewell (wife)</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertensive Cardio-Vasc. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>65 HRS.</u> <u>Years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-26-</u> , 19 <u>56</u> , to <u>7-28-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-28-</u> , 19 <u>56</u> , and that death occurred at <u>5:25</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D.				ADDRESS (Street, city or town, state) <u>9 N. Hanson St. Easton, Md.</u>			
DATE SIGNED <u>7-28-56</u>							
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>St Michaels, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Harrison</u> ADDRESS <u>St Michaels, Md.</u>				24a. REC'D BY REGISTRAR <u>8/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neerues</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

08706

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			c. LENGTH OF STAY IN 1b <u>5 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Memorial Hospital</u>			d. STREET ADDRESS <u>Federalburg</u> <u>05x-2</u>		
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>L.</u> Last <u>SMITH</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1908</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Harry Larrimore</u>			14. MOTHER'S MAIDEN NAME <u>ELLA L. Fisher</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-14-4297</u>	17. INFORMANT Address <u>Hospital Room 15 M Lawrence</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of Superior mesenteric vein</u> <u>570.2</u> DUE TO (b) <u>Thrombosis iliac artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ROSECTOMY OF ILEUM</u> (c) <u>ROSECTOMY OF ILEUM</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		M.D. <u>219 S. Washington St.</u>		DATE SIGNED <u>31 July 1956</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		<u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/3/56</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Federalburg</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Thompson Don Federalburg Md</u>			24a. REC'D BY REGISTRAR DATE <u>8/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Newell</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7625

CERTIFICATE OF DEATH

07611

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>Bar.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>Preston</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17 1956</u>
9. AGE (In years, last birthday) yrs. <u>4</u> Months <u>30</u> Days <u>4</u> Min. <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Morris Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Simmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Morris Thompson</u>	
17. INFORMANT <u>Father</u>		Address <u>Preston, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>July 17, 1956</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md</u> DATE SIGNED <u>July 19 1956</u> ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>E. C. H. Schmidt</u> PHYSICIAN'S NAME (Type) <u>Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incinerated</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital</u>		ADDRESS <u>Easton Md</u>	
24a. REC'D BY REGISTRAR <u>2/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7637

CERTIFICATE OF DEATH

Reg. Dist. No. 117512

1. PLACE OF BIRTH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>		c. LENGTH OF STAY IN 1b <u>13 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		d. STREET ADDRESS <u>Manfred</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Red Vista Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nataline</u> <u>Baynard</u> <u>Walter</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19 - 1863</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan H Green</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Montague</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Nataline Walter</u>		Address <u>Centerville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>944.9</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Fractured hip, late internal fixation - convalescent</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured hip, late internal fixation - convalescent</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 May</u> , 19 <u>56</u> , to <u>13 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>13 July</u> , 19 <u>56</u> , and that death occurred at <u>4:40 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R Lane Wrath</u>		ADDRESS (Street, city or town, state) <u>St. Michaels, Maryland</u>	
DATE SIGNED <u>7/14/56</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16 - 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnutfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Smith</u>		ADDRESS <u>Centerville Md</u>	
24a. REC'D BY REGISTRAR <u>Elvie Armstrong</u>		24b. REGISTRAR'S SIGNATURE <u>Elvie Armstrong</u>	
DATE <u>7/19/56</u>			

CERTIFICATE OF DEATH

Deceased: *John Brown*
 Residence: *1234 Main St*
 Date of Death: *July 15, 1956*
 Place of Death: *Home*

Cause of Death: *Heart Disease*
 Physician: *Dr. J. H. Smith*
 Burial Place: *Greenwood Cemetery*
 Burial Date: *July 18, 1956*
 Age: *65*
 Sex: *Male*
 Race: *White*
 Marital Status: *Married*
 Occupation: *Retired*
 Date of Birth: *July 15, 1891*
 Place of Birth: *Washington, D.C.*
 Date of Death: *July 15, 1956*
 Place of Death: *Home*

BUREAU V. 3

JUL 20 1956

RECEIVED

Received July 16-56
 Baltimore State Dept. of Health

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7626

CERTIFICATE OF DEATH

Reg. Dist. No. 27613

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyton Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) BABY ROY WASHINGTON		4. DATE OF DEATH Month July Day 3 Year 1956	
5. SEX MALE	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1956
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR: Months 15 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIRIAL WASHINGTON		14. MOTHER'S MAIDEN NAME ANNIE ROSE JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hirial Washington (father)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature 760.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Embryonal (c) hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 P. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E.C.H. Schmidt		DATE SIGNED 219 S. Washington Street 10 July 56	
PHYSICIAN'S NAME (Type) E.C.H. Schmidt		ADDRESS (Street, city or town, state) Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Interment		22b. DATE THEREOF 7-4-56	
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Easton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Interment Memorial Hospital		24a. REC'D BY REGISTRAR DATE 7/4/56	
24b. REGISTRAR'S SIGNATURE M.H. Nevers			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF BURIAL OFFICIAL	
17. SIGNATURE OF CHURCH OFFICIAL		18. SIGNATURE OF MINISTER		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF RABBI	
21. SIGNATURE OF JEWELER		22. SIGNATURE OF GEMSMAN		23. SIGNATURE OF OPTICIAN		24. SIGNATURE OF DENTIST	
25. SIGNATURE OF VETERINARIAN		26. SIGNATURE OF PHARMACEUTICIAN		27. SIGNATURE OF NURSE		28. SIGNATURE OF MIDWIFE	
29. SIGNATURE OF DOCTOR		30. SIGNATURE OF SURGEON		31. SIGNATURE OF OBSTETRICIAN		32. SIGNATURE OF PATHOLOGIST	
33. SIGNATURE OF ANATOMIST		34. SIGNATURE OF HISTOLOGIST		35. SIGNATURE OF MICROSCOPIC		36. SIGNATURE OF BACTERIOLOGIST	
37. SIGNATURE OF VIROLOGIST		38. SIGNATURE OF IMMUNOLOGIST		39. SIGNATURE OF RADIOLOGIST		40. SIGNATURE OF RADIOLOGIC	
41. SIGNATURE OF RADIOLOGIC		42. SIGNATURE OF RADIOLOGIC		43. SIGNATURE OF RADIOLOGIC		44. SIGNATURE OF RADIOLOGIC	
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93. SIGNATURE OF RADIOLOGIC		94. SIGNATURE OF RADIOLOGIC		95. SIGNATURE OF RADIOLOGIC		96. SIGNATURE OF RADIOLOGIC	
97. SIGNATURE OF RADIOLOGIC		98. SIGNATURE OF RADIOLOGIC		99. SIGNATURE OF RADIOLOGIC		100. SIGNATURE OF RADIOLOGIC	

BUREAU V. 3

JUL 13 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7627

CERTIFICATE OF DEATH

07614
Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>058-2</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Girl Wheatley</i>		4. DATE OF DEATH <i>July 24 1956</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1956</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Hobart Wheatley</i>		14. MOTHER'S MAIDEN NAME <i>Esther Dykes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr Hobart Wheatley</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intrauterine hemorrhage</i> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prematurity</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F.C.H. Schmidt</i>		DATE SIGNED <i>25 July 1956</i>	
PHYSICIAN'S NAME (Type) <i>F.C.H. Schmidt</i>		ADDRESS (Street, city or town, state) <i>219 S. Washington St. Easton, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7/25/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Memorial Hospital</i>	22d. LOCATION (City, town, or county) (State) <i>Easton Ind</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Memorial Hospital, Easton Ind</i>		24a. REC'D BY REGISTRAR <i>R.D. Meeren</i>	
ADDRESS		DATE <i>7/25/56</i>	

2080211XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF NOTARY	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF BURIAL	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
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RECEIVED

JUL 30 1937

BUREAU V. E.